Perceptions of Mothers and Health Professionals on Caesarean Section as A Way of Delivery at a County Referral Hospital in Nairobi, Kenya

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Abstract: Caesarean sections are often performed when mothers cannot deliver normally because either their life, the life of the unborn or their health is at risk. The aim of the study was to determine the perceptions of mothers and health professionals on caesarean sections, we conducted three focus group discussions with mothers who had delivered at Mama Lucy Kibaki Hospital and five key informant interviews with nurses working in maternity, labour room and reproductive health unit and medical officers conducting caesarean sections. The data were entered and managed in a qualitative data analysis package (Nvivo). Emerging themes and concepts were tracked and summarized. Three main themes relating to what determines how caesarean section is perceived by health professionals and mothers emerged: religion and culture; medical practice and safety and cost. Most mothers see caesarean section depending on how the society views it. Some cultures believe that women should deliver vaginally rather than undergo caesarean section which they consider artificial birth. Majority of Christian faiths support caesarean section especially in instances where either the life of the mother or the unborn is in danger. Some traditional churches though prohibit it. Among the Muslims, they don’t advocate for CS even under medical indications because it’s supposed to be a natural process. The health professionals’ perceptions of CS are guided by clinical indications and see it as only necessary for those who are medically indicated. They generally regard it as safe and affordable because it is free. The mothers though have myths about caesarean section birth, personality and society’s perception of those who have undergone it but given a chance majority would deliver through vaginal delivery. Myths and perceptions by mothers as influenced by religion and culture should be demystified so that mothers can access the right caesarean services when medically indicated.

Introduction
A Caesarean section is a surgical procedure in which one or more incisions are made through a mother's abdomen (laparotomy) and uterus (hysterotomy) to deliver one or more babies, or, rarely, to remove a dead foetus [1].

A Caesarean section is often performed when a vaginal delivery would put the baby's or mother's life or health at risk. Many are also performed upon request for childbirths that could otherwise have been vaginal [2].

In many developed countries, caesarean section rates have increased, and attention has focused on strategies to reduce use due to concern that higher caesarean section rates do not confer additional health gain but may increase maternal risks, have implications for future pregnancies and have resource implications for health services [3].

Caesarean delivery is thought to protect against urinary incontinence, prolapse, and sexual dissatisfaction, increasing its appeal [4]. The rise in numbers of women opting for a caesarean section might also be affected by obstetricians' defence of women's rights to choose their method of delivery [5].

Reports from various studies have indicated various findings as to what determines the ultimate choice of delivery with some showing that some mothers undergo CS even when they are not medically indicated as a result of their doctor’s advice [6]. Other studies also indicate that mothers are sometimes too willing to undergo the knife. Some have also been reported of being too posh to push [7]. In most cases, the views of those involved, the mothers and health workers are never sought and therefore their contribution in the debate is never taken.

Whereas it is important to know rates of people undergoing caesarean sections and what leads to the ultimate decision that a mother will undergo the knife it is also important to know how those involved
regard it. Caesarean sections are perceived differently by different people from different places. Globally, access to Caesarean sections could be regarded as advancement in medicine [8] while in Africa this changes depend on the culture and belief of those involved in making it either acceptable or prohibited[9]. In Kenya, the situation is no different and it is expected that the perception to CS more or less are in line with the cultural beliefs and faiths of those involved[10].

Materials and Methods

Study Population

For the focus group discussion, the study population included mothers who had delivered at Mama Lucy Kibaki hospital during the study period while for the key informant interviews it included nurse midwives working in the labour ward and maternity, medical officers that conduct caesarean sections at the study hospital and an obstetrician gynaecologist. Any participant who failed to consent for the study for personal or professional reasons was excluded.

Study design

This was a cross sectional study using qualitative methods.

Sample size

We conducted three focus group discussions each consisting of 10 participants. The participants were in three groups: those who had delivered through CS, those who underwent SVD and a group that consisted of a mixture of both who underwent CS and those who delivered through SVD. In addition, we conducted key informant interviews with interviewed two nurses, two medical officers and an Obstetrics and Gynaecology consultant. For the FGD we excluded any mother who did not deliver at the study hospital or who did not consent to participate in the study. Health care workers who did not consent to the study or worked in other departments other than labour room and maternity were excluded.

Data collection

For the focus group discussions, checklists were used while interview schedules were used for key informant interviews. For the FGDs, we had a round table discussion with the participants on their perceptions on caesarean sections and their contributions were captured in form of notes. Observations were also made to enrich the discussions. For the KIIs the participants were interviewed face to face on their perceptions on caesarean sections as health care workers as interview notes were being taken. The interviews and FGDs were all conducted in English since it was the most comfortable language for all the participants.

Data management

Observations and notes were entered and managed using Microsoft Word and were input into a qualitative data analysis software package (Nvivo). Expanded notes were reviewed and emerging concepts and themes were identified from the focus group discussion and the key informant interviews. The emerging concepts and themes were tracked and summarized in a table throughout data collection. Codes were created and a codebook was developed based on the summary table. Codebook definitions were refined, and further analysis conducted to identify additional themes and patterns. A process of constant comparison between interviews was used to consolidate dominant themes and data collection ceased when “saturation” was achieved, with themes and scenarios being repeated in successive interviews. We used constant comparison in our analysis to ensure that the thematic analysis represented all perspectives. The findings from the analysis were summarized and compiled.

Results

We conducted three focus group discussions each consisting of 10 mothers who had delivered at the study hospital with equal numbers for CS cases and SVDs. All the mothers were residents of Kayole and Umoja estates between the ages of sixteen and forty nine years. We also conducted 5 key informant interviews; 2 nurses, 2 qualified medical officers and a consultant.

The following sections summarise the themes” (numbered) and “subthemes (lettered) that emerged from the analysis of the data from the FGD and KIIs.

1) Perception of health professionals

(a) Cost of caesarean section

On inquiring about the cost of caesarean sections all the key informants agreed that the service was provided for free at the hospital it being a government hospital and therefore everybody was able to afford. Although the caesarean section costs no money there were other charges reported including payment for file and lab tests. One of the respondents had this to say:
“With the free maternity services, it’s free except for opening the file which costs Kshs. 500 and Lab which cost Kshs. 200.”

All key informants concurred that the vaginal deliveries were free since the introduction of the free maternity services in Kenya. This was supported by one of the key informants who had this to say;

“……..they are supposed to pay Kshs. 5,500 but they don’t pay. They walk in deliver and walk out. We do just do the billing for record purposes and for reimbursement from the government.”

(b) Availability

Caesarean Section services were reported to be available at all time with standby nurses, anaesthetists and medical officers. Besides, the hospital has two theatres that are available and even if one theatre is down, the other theatre can be used. However, there were instances reported where the hospital was overwhelmed and mothers had to be referred to another hospital. Following are some excerpts from the key informants;

“……we have two theatres. When one is down the other is operating.”

“…..yes, sometimes we have accessibility problem. Sometimes mothers are many and they are referred to Pumwani (a referral maternity hospital). Very rarely though. Especially when only one theatre is operating and mothers are at risk.”

(c) Indication of CS

All key informants agreed that there were no instances where a mother who should have delivered through vaginal delivery was taken through CS. They reported that in government hospitals caesarean sections were only conducted on those who were medically indicated. The hospital conducts elective CS on Wednesdays and Fridays while emergency CS is conducted when needed. In addition, it was also reported that most mothers who came to the hospital for delivery through CS were referred from other health facilities (peripheral and or private clinics) some key informants had to these to say;

“In this hospital, this is rare. I have not heard. We don’t take mothers who request. We only take electives and emergencies. ”

“In a government hospital without indications no CS is done.”

(d) Medical competency and safety of CS

Competent staffs including qualified medical officers, consultants, and obstetrician gynaecologists are available to conduct CS when necessary. There were Medical officer interns working under supervision from qualified staff who also conduct the operations only in the presence of qualified personnel.

“For us to conduct any CS it’s always mandatory to have all the required personnel in the theatre. We have the consultant or the obstetrician gynaecologist, anaesthetist, a nurse and other supporting technical staff. Sometimes we have the medical officers carry out the CS, with nurses and anaesthetist. Medical officer interns are only allowed to conduct CS under the supervision of a qualified doctor. So yes, we always have qualified personnel to carry out the procedure whenever it is needed…”

On the safety of CS, the key informants reported that CS was safe if it is done in procedural ways and that mortality cases are very rare except in cases where the mother comes with underlying factors such as mismanagement from peripheral private clinics, mothers arriving in late stages among other factors. One of the key informants who had previously undergone CS at the hospital had this confession to make;

“Yes, they are safe because I am a victim. If it’s the only mode for that mother although if there’s no contraindication, SVD is the way to go.”

The key informants also reported that the maternal mortalities after CS cases are there but very rare and mainly occur in case the uterus fails to contract after CS and when postpartum haemorrhage ensues and there is no blood in the hospital blood bank.

“Deaths during the process of CS are not very common here but sometimes it can happen mostly when the womb of the mother fails to contract after the procedure or when the mother bleeds severely and we don’t have the required blood in the hospital…..”

On whether they knew of any guidelines that regulate conducting of CS, no key informant was committal with all of them stating the medical indications for CS as the guidelines. This is what one key informant had to say;

“The little I know is that I don’t know whether it’s a national guideline- a mother of previous scar is planned for elective, a mother of APH more so placenta praevia, a mother who comes with a CPD will definitely go for CS, obstructed labour,…………..”
(2) Perceptions of mothers on caesarean sections

(a) Individual choices

We had a discussion with the mothers on what determines their choices when it comes to undergoing caesarean sections and various views were given. There were a group of mothers who said that they would prefer to undergo normal vaginal delivery because of the benefits that come with it such as healing faster, taking shorter period before resuming active sexual life, being able to be physically active immediately after child birth and resuming routine chores. They said they were against caesarean section because those who undergo CS have difficulties holding their babies properly because of the wound and because of the stereotypes associated with those mothers who have undergone CS such as them being not ‘normal’. The other group of mothers were torn between the two with others opting for CS while others saying they could only know the right mode after experiencing both. Those who supported CS said that it is painless and do not disfigure their genitalia. They remain ‘intact’. These are some of the excerpts from the focus group discussion:

“I will pick normal. I am talking from experience. I delivered normally and I did not have any problem. I healed fast. Within two to three days you are O.K. for CS I don’t know but I hear they complain that they are weak and can’t work.”

“Not unless I experience both. I can’t tell.”

“I underwent CS and was ok after three days. It depends on good care. If you get a good doctor it heals faster.”

“………….. Normal. Because the complications involved with CS like time I’d take to heal and also given that it is my tradition. CS disables me in a way. So I’d go for normal.”

(b) Religion

Religious stand on caesarean section depended on one’s faith. Among the Christians CS is not prohibited and as long as it is done under medical advice to enhance life of the mother or to prevent loss of life of the unborn it is allowed. Among those who believe in the African traditional religion they don’t allow it. Others also said that their churches had no stand on CS and that mode of delivery was a personal choice. Among the Muslims also it was reported that birth should progress normally as planned by God and therefore CS is not encouraged even under medical advice and that even in cases of emergency it should not be done because the life of the mother is the will of God and if it’s God’s will for the mother to die the CS will not prevent it. Below are some excerpts from the focus group discussion.

“For me, my religion says nothing. I think it is in support of giving everyone a chance to live so if CS supports life it is for it. ……..”

“Its personal choice…………”

“CS is accepted. When the life of a mother is in danger it should be done once a doctor has said. Our church doesn’t prohibit.”

“Traditional churches don’t allow……………….”

“As Muslims we believe that Only God gives and takes away life and that His will should be accepted. To us child birth is a natural process and should remain so. It is God’s plan for humanity. We don’t support CS.”

(c) Cultural beliefs

Persons form different cultures perceive CS differently. During the discussion some participants said that in their culture CS is prohibited because it limits the number of children a woman can have when they are expected to have many children and that it makes mothers disabled after birth preventing them from performing their duties. Other cultures allow it but do not perceive those who have undergone it as “women enough”

“………………my mother in law was against it. She told me they have never seen it in their family. They believe birth is a natural process and it should happen the way God planned it……………….”

“……………i know no culture that prohibits CS but I hear people say if you go through CS haujatosha mboga (you are not woman enough).”

“In our culture it is allowed but she is seen as not woman enough because she hasn’t undergone labour pain.”

(d) Misconceptions about caesarean sections.

There were various misconceptions about CS that the mothers shared with us including that; if one undergoes CS for her first birth she will undergo CS
for all the succeeding births, that CS is not real birth because no labour pain is involved, that one will feel pain in the scar for the rest of their lives, that if someone who has undergone CS stands for long, the scar will tear off, that mothers who have undergone CS should not expose their scars to expectant women because if they do, they will also deliver through CS and that they cannot do physical work after the delivery. The other myths were that once one has undergone CS they have to wait longer sometimes up to five years to conceive, that the most number of children one can have after CS is three and that after CS one develops progressive constipation. Below is an excerpt from the discussion.

“I have been told that if I stand for long my scar will tear off......”
“‘My friend was told not to expose her scar to expectant women because she will make them to also undergo CS.......’
“I was told that I will never have more than three children that others will be better than me......”

Discussion

The perception of mothers on caesarean section is determined by their cultural belief, the religion they profess and influence from peers and friends. A study conducted on Perceptions of Women and Obstetricians about Cesarean Sections for Nonclinical Indications [7] had similar findings where some women gave birth through CS as a result of a discussion with friends or family or contacting family members for advice on the mode of delivery before opting for one. Religion also plays a major role on how a mother perceives CS as a mode of delivery with Muslims and traditional churches faithful not accepting CS under any circumstances.

It was also found that when it comes to personal choice, women perceived birth by CS in terms of safety and as a ‘saviour’ against the labour pain. This finding is similar to the findings in a study conducted in Australia that reported that childbirth fear, issues of control and safety, and a devaluing of the female body and birth process were the main reasons underpinning women’s requests for a non-medically-indicated caesarean section. Women perceived that medical discourses supported and reinforced their decision as a ‘safe’ and ‘responsible’ choice [11] It should also be noted that in the African setting, mothers-in-law have a lot of say when it comes to the reproductive life of their daughters in law from the number of children to be born. This authoritative determines how a- would- be mother perceives CS in relation to another mode of delivery. This is similar to the findings of a critical review of literature on elective caesarean and decision making that found that in the absence of clinical indications women’s preference for a caesarean section is related to psychological factors, perceptions of safety, or in some countries, was influenced by cultural or social factors [12]

Health professionals perceive that CS is safe and that only mothers who are medically indicated should undergo the procedure. They also perceive that the services are accessible and available since the government made maternity services free to all. The health professionals more or less make their judgements based on medical indications. Similar finding was reported in a study on women’s experience of decision making about mode of delivery after a previous CS. It stated that Health professionals generally took a supportive role whichever mode of delivery was chosen.

Conclusion

Perceptions of both mothers and health professionals play a big role in determining whether a mother undergoes a caesarean section or not. This calls for more information to the mothers so to demystify the myths they have and more emphasis to health professionals to ensure the right practice.

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References


